## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		CONSTRUCTION 01,04	(X3) DATE SURVEY COMPLETED		
		155766	B. WIN	3			R <b>4/2011</b>	
NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR CHRISTIAN HOME INC				643	ET ADDRESS, CITY, STATE, ZIP CODE WEST UTICA ST LLERSBURG, IN 47172			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO T DEFICIENCE)		ON SHOULD BE COMPLETION IE APPROPRIATE DATE		
{K 000}	INITIAL COMMENTS		{K 0	00}				
	Code Recertification conducted on 07/21/ Indiana State Depart accordance with 42 (Survey Date: 08/24/ Facility Number: 000/ Provider Number: 18/ AIM Number: 10026/ Surveyor: Mark Bug Specialist  At this PSR survey, Minc. was found in corfor Participation in Minc. Subpart 483.70(a), L 2000 edition of the Ninc. Association (NFPA) and 410 IAC 16.2. Timestrated in the conduction of the Ninc. Mark 10/ IAC 16.2. Timestrated in the conduction of the Ninc. IAC 16.2. Timestrated in the Conduction of the Ninc. IAC 16.2. Timestrated in the Conduction of the Ninc. IAC 16.2. Timestrated in the Conduction of the Ninc. IAC 16.2. Timestrated in the Conduction of the Ninc. IAC 16.2. Timestr	CFR 483.70(a). 11 0563 55766 7610						
	determined to be of and fully sprinklered. system with smoke d spaces open to the c smoke detection in the resident rooms. The and had a census of Quality Review by Rocode Specialist-Med	with a basement was Type V (000) construction The facility has a fire alarm letection in the corridors, orridors, and single station ne 100 Hall and 200 Hall facility has a capacity of 57 54 at the time of this visit.  Subsett Booher, Life Safety ical Surveyor on 08/25/11.						
{K 000}	INITIAL COMMENTS		{K 0	00}				
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		155766		A. BUILDING 01 , 04  B. WING		R <b>08/24/2011</b>	
NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR CHRISTIAN HOME INC				6	REET ADDRESS, CITY, STATE, ZIP CODE 643 WEST UTICA ST SELLERSBURG, IN 47172	U8/24	1/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE	
{K 000}	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		{K (	000}			